

Division Circular #34

**DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES**

EFFECTIVE DATE: June 1, 1999

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(Replaces Division Circular #34, "Behavior Modification Programming for the Treatment of Maladaptive Behavior", issued on 7/1/93)

- I. TITLE: BEHAVIOR MODIFICATION PROGRAMMING**
- II. PURPOSE:** To provide guidelines and procedures for the development, implementation and evaluation of individually prescribed behavior modification programs.
- III. SCOPE:** This circular applies to all components of the Division as well as providers under contract with or regulated by the Division.
- IV. POLICIES:**

The Division of Developmental Disabilities recognizes that adaptive behavior is fostered and maintained by meeting certain basic needs. These basic needs shall be considered before employing any behavior modification program.

The basic needs include but are not limited to:

- a. Sufficient living area.
- b. Nutritious diet.
- c. Access to therapeutic services, structured programs and leisure activities which are enjoyable as well as instructive and age-appropriate.
- d. Effective sanitary practices.
- e. Personal possessions which are age-appropriate, functional, preferred by the individual and which are available for use.
- f. Frequent communication and positive interactions with others.
- g. Recognition through the words and actions of others that the individual is a valued and respected person.
- h. Opportunity for the development of functional and societally appropriate social, communication and coping skills.

All individually prescribed behavior modification programs shall be designed in accordance with professional ethical standards and currently accepted practice. These individually prescribed behavior modification programs shall be developed on the basis of a reasonable expectation of effecting future behavioral improvement by the individual. Maximum respect for the individual's personal dignity shall be reflected.

All approved individually prescribed behavior modification programs shall be incorporated into the Individual Habilitation Plan (IHP).

Whenever possible, strategies in Level I should be used to help people learn new behaviors or cease to engage in behaviors that are personally counter productive.

The Division recognizes that in addressing certain behaviors, Level I strategies alone may not be effective. In such instances, Levels II or III strategies may be approved in accordance with the policies outlined in this circular. There shall be documented evidence that Level I strategies have not been sufficiently effective and/or that the exhibited behavior is so dangerous to self or others as to require the immediate use of Levels II and/or III strategies. The Division further recognizes that in certain cases, the least restrictive yet most effective strategy may be a Level II and/or III. It is not the Division's intention to imply a necessary correspondence between behaviors and strategies such that more difficult behavior problems require more aversive techniques but to allow for the possibility that such a relationship exists.

No component of the Division or any service provider shall be authorized to implement individually prescribed behavior modification programs using Levels II or III strategies without having a comprehensive written procedure manual. The manual shall have been approved in writing by the Director, Division of Developmental Disabilities.

Service providers may elect to develop a Memorandum of Understanding with the appropriate regional office(s) of Community Services to use the Division's Community Services Behavior Management Manual.

Individually prescribed behavior modification programs may only be implemented when in full compliance with the standards of this

circular and the Division's components or service providers approved policies and procedures.

When the individual receives services from more than one agency, staff from those agencies shall cooperate in developing a single comprehensive behavior program. Ultimately, consensus on the individually prescribed behavior modification program is essential.

Level II or III strategies shall not be used for the convenience of staff or as a substitute for activities or more appropriate treatment. The application of any strategy in willful violation of provisions of this circular may be construed as physical, psychological and/or verbal abuse.

Research potentially affecting the health, safety or welfare of the individual must be approved in accordance with the Division Circular #27.

Seclusion (placing an individual alone in a locked room) shall be prohibited except as shall be specifically authorized by the Division Director. A room used for the purpose of implementing a time out procedure as described in the circular shall not be considered to be seclusion.

V. **STANDARDS:**

- A. Definitions – For the purpose of this circular, the following terms shall have the meanings defined herein:
1. Behavior Management Committee (BMC) – Refer to Division Circular #18.
 2. Chief Executive Officer (CEO) – means the person with administrative authority over a developmental center, a provider agency or a private mental retardation facility licensed in accordance with N.J.A.C. 10:47.
 3. Human Rights Committee (HRC) – Refer to Division Circular #4.
 4. Informed Consent – Refer to Division Circular #41.
 5. Interdisciplinary Team (IDT) – Refer to Division Circular #35.

6. Regional Administrator (RA) – means the person with administrative authority over a Regional Office of Community Services.

7. Target Behavior – Any operationally defined behavior that is the focus of an individually prescribed behavior modification program.

B. Clinical Guidelines for Individually Prescribed Behavior Modification Programs

All individually prescribed behavior modification programs shall emphasize the development of alternative, adaptive behaviors rather than merely the elimination or suppression of maladaptive ones. Therefore, all individually prescribed behavior modification programs utilizing Levels II or III procedures shall also include provisions for teaching and positively reinforcing adaptive behavior.

Behavior programs shall provide procedures for maintenance and generalization to relevant living and program environments and shall include provisions for revision when significant positive changes in the target behavior(s) are not achieved within the established time frames.

In addition to compliance with the guidelines listed above, all individually prescribed behavior modification programs shall be based upon information which is included in the behavior program or referenced in existing reports available in the client record.

Behavior programs shall have the following components.

1. Description of the presenting problem:
 - a. A clean description of the presenting problem using operationally defined terms.
 - b. Antecedent behaviors, if known, which shall be listed in the sequence in which they typically occur.
2. Relevant Background Information: A brief description of the individual and relevant background information, such as the individual's age, sex, level of functioning, medical history, medication history, physical disabilities, communication skills, etc. The individual's background shall be considered when the program is developed.

3. Description of Previous Intervention Approaches: A short summary of previous intervention approaches, how long they were used, and their outcome.
4. Behavioral Assessment and Functional Analysis: While related and overlapping, these two processes emphasize different aspects of the behavior modification situation. These processes shall continue throughout the implementation of a behavioral program, especially when the program is implemented in more than one setting and/or by several workers. Evidence shall be available that comprehensive behavioral assessment and functional analyses were conducted, including but not limited to the following information:
 - a. Data on the target behavior (e.g., frequency, intensity, duration); typically referred to as "baseline" data.
 - b. Data showing the specific circumstances in which the behavior occurs and does not occur using standard behavioral data collection methods.
 - c. Assessment of the antecedents and consequences of the behavior.
 - d. Analysis of the function that the behavior has for the person (e.g., attention-seeking, avoidance, communication).
 - e. An analysis of the person's environment(s) in regard to availability of reinforcement, availability and appropriateness of activities, level/type of social interaction, physical characteristics, and so forth especially as these elements relate to the target behavior.
 - f. Identification of current and potential reinforcers especially as they relate to aspects of the person such as likes and dislikes, interests, and other personal characteristics.
 - g. A relevant inquiry into the medical status of the person; for cases in which there may be a medical

cause for the target behavior, written certification by a physician that such causes have been evaluated and ruled out or are being further explored must be provided.

- h. Current medications, reasons for taking medications, and any side effects of medications that are relevant to the target behavior.
 - i. Information from additional evaluations, if indicated.
5. Description of the Proposed Intervention: This shall include:
- a. A description of the proposed strategy.
 - b. If a Level II or III strategy is used, a strategy for teaching/increasing appropriate alternative behavior.
 - c. A discussion of the anticipated effects, side-effects, risks, and benefits of the intervention.
 - d. A description of the procedures designed to ensure maintenance and generalization.
6. Medical Clearance: The need for medical clearance is evaluated by the IDT. Under some circumstances, an individual's medical and/or physical condition may be adversely affected by a particular intervention (e.g., physical restraint applied to an individual with a limb dysfunction, heart condition, etc). In such cases, written certification by a physician and the use of the proposed intervention is not contraindicated by the individual's physical or medical condition shall be provided.
7. Rationale for the Proposed Intervention: This should include an explanation of how the proposed intervention addresses the target behavior with specific regard to the information obtained through the behavioral assessment. A literature review supporting the use of the proposed intervention may be provided or maintained on file for interventions which deviate from the mainstream of clinical practice which may be viewed as controversial. If the techniques deviate from the mainstream of clinical practice or may be viewed as controversial, a literature review supporting the use of the

proposed intervention shall be provided and maintained on file.

- C. Credentials shall be designated for staff members responsible for developing behavior modification programs (except for Level I).
1. Authors of behavior modification programs shall at a minimum have:
 - a. A bachelor's degree in psychology, special education, sociology, guidance and counseling or social work.
 - b. One year of experience in working with developmentally disabled persons involving behavior modification.
 2. Staff positions shall be designated who will be trained and authorized to apply the specific program.
 3. Staff who are authorized to implement the individually prescribed Behavior Modification Program shall complete the following training:
 - a. Orientations to behavior management strategies.
 - b. Orientation to Abuse and Neglect policies.
 - c. Specific in-service training, with appropriate documentation, prior to the implementation of an individually prescribed behavior modification program, to teach proper application of behavioral strategies.
 4. Staff member skills will be monitored on a periodic basis to ensure competency.
 - a. Designated staff shall show the ability to:
 1. Identify target behaviors.
 2. Demonstrate application of behavioral strategies.
 3. Demonstrate the ability to collect data.
- D. Approval Requirements for Individually Prescribed Behavior Modification Programs

1. If an individually prescribed behavior modification program employs strategies from more than one category, the most extensive approval procedure, appropriate to the category used, shall be followed.
2. Level I requires the approval of the individual's IDT.
3. Level II requires approval of the individual's interdisciplinary team which must include a member with behavioral expertise in compliance with the credentials cited under V.C.I of this circular.
4. Level III requires the approval of:
 - a. BMC
 - b. HRC
 - c. If an emergency exists, approval by the full BMC and chairperson of the HRC may be granted with full HRC review to follow.
 - d. Informed consent
 - e. CEO or RA approval.
5. Medical Certification

Shall be secured when, in the judgement of an IDT, the strategy presents an element of physical risk to the individual. Written certification from a State licensed physician shall indicate that the individual's medical condition does not preclude the use of the proposed behavioral strategy(ies). In assessing the potential for physical risk, an individual's pre-existing physical, psychological and medical conditions shall be considered.

6. Informed Consent

Refer to Division Circular #41 for specifics.

MANDATED APPROVAL MECHANISMS

LEVEL	IDT EVALUATION	BMC	HRC	MEDICAL CERTIFICATION	INFORMED CONSENT	CEO OR RA
I	X			**		
II	X*			**		
III	X*	X	X	X	X	X

*IDT must include a member with behavioral expertise in compliance with the credentials cited under V.C.I of this circular.

**Must be obtained if in the judgement of the IDT, the strategy presents an element of physical risk to the individual.

E. Levels of Approval

The Division recognizes the vast array of behavior management interventions in current practice. The Division has placed strategies into three levels using a combination of many factors such as risk of physical injury, risk of improper implementation, restrictiveness, and social acceptability. Each level coincides with the necessary approval mechanisms for safeguarding the individuals served. The Division requires that strategies in each level receive the corresponding approval.

Level I

Correction – Requiring an individual who has disrupted a social or physical environment to restore that environment to its “normal” state utilizing verbal/ gestured prompts.

Differential Reinforcement of:

1. Alternative Behavior – Reinforcing an alternative behavior which serves as a functional substitute for the target behavior.
2. Communication Behavior – A type of differential reinforcement of alternative behavior which involves reinforcing an appropriate communicative act (e.g., verbal, gestured) which serves as a functional substitute for the target behavior.
3. Higher Rates of Behavior – Reinforcing the target behavior when it occurs more than the specified number of times per interval.
4. Incompatible Behavior – Reinforcing a specified behavior which is physically or functionally incompatible with a target behavior.

5. Lower Rates of Behavior – Reinforcing the target behavior when it occurs less than the specified number of times per interval.
6. Other Behavior – Reinforcing at the end of a specified interval for engaging in any behavior other than the target behavior during that interval.

Extinction – Withholding a consequence that has been maintaining or increasing a target behavior.

Time Out from Positive Reinforcement – Removing an individual from the presumed source of reinforcement for the target behavior, using only gestured/verbal prompts for a period not to exceed five (5) minutes.

Pointed Praise – Ignoring the target behavior of an individual while praising the behavior of other individuals.

Relaxation Training – Any skill training designed to elicit a relaxation response.

Sensory Stimulation – Providing sensory stimulation presumed to be reinforcing to the individual which is intended to decrease the target behavior.

Stimulus Change – Introducing and/or altering a visual or auditory stimulus which is intended to produce a transitory period of target behavior reduction.

Stimulus Control – Providing and/or maintaining stimulus (e.g., environmental) conditions which set the occurrence or nonoccurrence of a target behavior.

Level II

Correction – Requiring an individual who has disrupted a social or physical environment to restore that environment to its “normal” state utilizing verbal gestured prompts.

Negative Practice – Requiring the individuals to repeatedly practice the target behavior with verbal/gestured prompts.

Response Cost – Removing predetermined reinforcers (e.g., tokens, privileges) contingent upon the occurrence of target behaviors. The predetermined reinforcers may not include the removal of personal property or access to routine community activities.

Satiation – Providing unlimited access to those reinforcers that have been maintaining the target behavior.

Time Out from Positive Reinforcement – Removing an individual from the presumed source of reinforcement for the target behavior, using verbal, gestural and/or physical prompting/manual guidance without significant resistance for a period not to exceed fifteen (15) minutes.

Level III

Aversive Stimulation – Contingently applying an aversive stimulus. The aversive stimulus must be documented as eliciting an escape or an avoidance response (e.g., lemon juice, ammonia capsules, water mist, etc).

Manual Restraint – Restricting the individual's freedom of movement either partially or totally by means of personal control techniques. Personal control techniques are considered distinct from physical prompting which is a procedure involving physical contact for the purpose of acquisition of a specific skill or behavior.

Meal Modification – Contingently altering any aspect of an individual's normal meal routine including the amount consumed (not the nutritional value) as well as when and where it is consumed, as part of a planned behavioral program.

Mechanical Restraint – Contingently applying a device that restricts movement (e.g., helmet, wrist and ankle ties) as distinguished from its emergency use addressed in Division Circular #20.

Overcorrection with or without Positive Practice – Requiring the individual to overcorrect the environment or social effects or other consequence of the target behavior.

Response Cost – Removing predetermined reinforcers, which include personal property or routine community activities contingent upon the occurrence of the target behaviors.

Sensory Masking – Contingently blocking sensory input. The use of such items as hoods, pillow cases and sacks as facial screens is prohibited.

Time Out from Positive Reinforcement – Using any time out procedures not described in Categories A and B.

Time Out from Positive Reinforcement in a Designated Room – Temporarily removing an individual from positively reinforcing events to a room used exclusively for the purpose of implementing a time out from positive reinforcement intervention procedure. The implementation of this procedure is contingent upon an occurrence of a specified target behavior.

- F. Any highly aversive technique not specifically listed in this circular such as electric shock, contingent slapping, automated vapor spray, etc. may not be used under the terms of this circular without specific review and approval by the Division Director and the appointment of a guardian ad litem when appropriate.

- G. Authorization to Use Level II and III Strategies in Individually Prescribed Behavior Modification Programs
 - 1. Authorizations may be made as follows:
 - a. Any developmental center, private residential facility, the Office of Community Services or private agency requesting approval to utilize Level II and/or III strategies must submit to the Director, Division of Developmental Disabilities, a comprehensive written procedure manual governing the use of such interventions.
 - b. The use of Levels II and/or III strategies in a Division operated day program or in a Community Care Home licensed and regulated under N.J.A.C. 10:44B shall be developed through the Regional Office in accordance with the Community Services Behavioral Manual.
 - c. A community based provider agency may elect to use the Community Services Behavior Manual rather than develop an independent manual. The provider

agency shall develop a Memorandum of Understanding governing how the Community Services Behavior Manual will be utilized. That Memorandum of Understanding shall be developed in cooperation with the Regional Office.

2. Manuals submitted shall address the following:
 - a. The agency's philosophy with respect to behavior management programs.
 - b. The specific categorized behavioral strategies which shall be authorized.
 - c. Procedures describing the intervention process. Procedures shall address behavior assessment and functional analysis and strategy development as outlined in this circular.
 - d. Staff training programs and procedures to assure staff competence.
 - e. Description of the approval process.
 - f. The maintenance of a central file of individually prescribed behavior modification programs using Level II or III strategies that are currently employed at the facility. This file shall be available at all times.
3. All manuals and Memorandums of Understanding shall be submitted to a review committee appointed by the Division Director.
 - a. The nature of the population served, conformity with the requirements of this circular and other relevant criteria shall be considered.
 - b. The committee may request clarification or suggest changes. The comments of the committee shall be provided to the agency in writing.
 - c. When submitting revisions, the agency shall include a cover memorandum which specifically identifies each

change made and cite where the change occurs in the revised manual.

- d. All changes shall be reviewed by the committee.
- e. When the manual is felt to comply with the circular, the committee shall recommend approval to the Director.
- f. If an agency wants to assign a specific technique to another level of approval, they may submit the rationale in writing to the review committee.
- g. The Director shall advise the applicant in writing of the results of the review. The Director may approve the manual fully, may issue a contingent approval based upon specific changes suggested or may reject the manual.
- h. A copy of the fully approval manual shall be forwarded to the committee chairperson and to each regional office in which the private provider operates programs.
- i. The Division Director may order determination of a manual or a specific program using aversive techniques if requirements of this circular are violated.

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Director